STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219

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F0000	This visit was for the investigation of Complaint Number IN00085321. This visit was in conjunction with the Recertification and State Licensure Survey. Complaint number IN00085321 - Substantiated; Federal/State deficiencies related to the allegations are cited at F253. Survey dates: February 21, 22, 23, 24, 25, 2011 Facility number: 000222 Provider number: 155329 AIM number: 100274950 Survey Team: Deb Barth, RN, TC Donna Downs, RN Brenda Buroker, RN Lois Corbin, RN Census Bed Type: 020 SNF 137 SNF/NF 157 Total Census Payor Type: 035 Medicare 089 Medicaid 033 Other 157 Total	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 43 This deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality review completed 3-3-11 Cathy Emswiller RN			

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F0253 SS=E	Based on observation, interview and record review, the facility failed to ensure resident rooms and common areas for residents were maintained in a clean and sanitary manner. This affected 80 of 91 resident rooms, 144 of 157 residents residing in the facility, and 8 of 11 common areas in the facility. Findings include: 1. Room 161 was observed on 2/21/11 at 9:40 a.m. The resident was sitting in a chair facing the window. The resident's room, common bathroom shared between this resident room and room 163 had a strong odor of urine. During a record review of the bed inventory, these two rooms contained 1 resident each. 2. On 2/23/11 at 2:15 p.m. the following was observed: The shower room on the "F" hall was soiled with a brown substance in the tile gout outside the shower area 4 feet in length, with a rubber mat covering the length of it. The edging between the floor and the wall was coming loose to the left of the entry door measuring 3 feet long. Inside the closet, there was an opened bottle of shaving cream, lotion, and deodorant lying on the	F0253	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after March 27, 2011. It is the practice of this provider to ensure that all alleged violations involving Housekeeping & Maintenance Services are in accordance with State and Federal law.	03/27/2011

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	floor. There was a hole in the entry door (interior side of door) about 2.5 feet from the floor extending 18 inches, and another hole exposing the interior door 3 inches x 1 inch in size. 3. On 2/23/11 at 2: 20 p.m. the unit manager RN/unit manager # 1 came to the F hall shower room when the call light was being checked for functioning. During an interview with the RN/unit manager #1, she indicated this was the F hall shower room. She indicated she did not know what the brown substance was in the tile grout around the exterior bottom of shower "possibly dirt don't know." There were several opened items lying on the closet floor. RN/unit manager #1 indicated they were shaving cream, lotion, and deodorant for individual resident use. When interviewed at that time, she indicated the residents usually have their own individual personal items, but they might use these items if they forgot to bring their own to the shower room. She immediately picked up all 3 items off the floor and discarded them in the trash can. She indicated the facility process for sanitizing shower chairs included spraying them with use a sanitizing solution then wiping them off. She was unable to		**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The common bathroom between room 161 and room 163 was deep cleaned. The F hall shower room was deep cleaned the brown substance on the tile grout was eliminated. The edging between the floor and the wall was repaired. All personal items were removed from closet. The holes on the interior side of the entry door were repaired. Shower rooms were stocked with appropriate cleaning solutions. The entry door frames to the resident rooms on F, G, and H hall have been sanded and repainted. The hole in the soiled utility room on H hall was repaired. The dry rot noted on room 151 door frame was repaired. The clean utility room on F hall was cleaned. The entry door frames to resident rooms on D and E hall have been sanded and painted. Dining room #1 the scrape on the wallpaper exposing dry wall was repaired. The automatic doors in dining room #1 were repaired. Dining room #2 the wallpaper on the north wall was repaired. The doors to the outside of the building were painted. The door frames on the AC hall have been sanded and painted. The door	

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	locate any of this sanitizing cleaning solution, and checked with another nurse at the nurse's station who said it was in the H hall shower room". 4. On 2/23/11 at 2:25 p.m., RN/unit manager #1 went to the hall H shower room with the surveyor to point out the sanitizing solution used to sanitize the shower chairs. There was one empty 34 ounce spray bottle of comet/bleach liquid. 5. On 2/23/11 at 2:40 p.m. the following was observed: The resident rooms on the F, G, and H rehabilitation halls had entry doors/frames marred and scuffed with black marks with paint chipped off. A record review of the completed facility Bed Inventory sheet indicated these halls contained 35 rooms and 54 residents. 6. During an observation on 2/23/11 at 2:43 p.m., the soiled utility room on the H hall was noted to have a hole in the upper left wall about 2 feet from the ceiling the size of (2) 50 cent pieces. 7. During an observation on 2/23/11 at 2:46 p.m. there was dry rot noted on room 151 door frame 6 inches in length.		frame on room C126 was repaired. The scuffs and black marks to the C hall common shower room walls were repaired. The shower chair and cushion were cleaned. The ceramic tile in the shower room was deep cleaned. The C hall clean utility room was cleaned and sanitized. The B hall entry and door frames to resident's rooms were sanded and painted. The common area couch and chair were cleaned. The soap dish rack in the H hall shower room was repaired. The shower chair was cleaned. Memory Care 1 unit entry door frames were sanded and painted. Memory Care 1 activity area wallpaper was repaired. The common activity area was cleaned by housekeeping. The treatment carts on C hall and H hall were cleaned. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. SDC or designee will educate CNA's on appropriate shower chair cleaning. Housekeeping supervisor or designee	

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	8. During an observation on 2/23/11 at 2:48 p.m. the clean utility room on the F hall was found with a paper cup with straw in it, paper cup with drink in it, and a bedspread lying on floor. There was a pair of disposable gloves inside out appearing to have been used lying on floor, a straw on floor, and another cloth linen lying on floor. 9. During an observation on 2/23/11 at 2:55 p.m., all of the resident rooms on the D and E hall were noted to have door frames/doors scuffed. A review of the facility completed Bed Inventory sheet indicated these two halls had 12 rooms with 24 residents. 10. On 2/23/11 at 3:10 p.m.,dining room #1 was observed. There was a scrape on the wallpaper exposing partial drywall 3 feet in length. The automatic doors in this dining room did not function when the automatic door knob was pressed. Both doors opened when pushed and no alarm sounded. The maintenance supervisor was informed and he indicated he was aware of this and the outside courtyard to the doors was secured with a lock on the fence. 11. On 2/23/11 at 3:15 p.m., the dining room #2 was observed. There		will educate facility housekeepers on appropriate cleaning schedules of activity areas, shower rooms, and utility rooms. Facility department heads will complete daily rounds Monday thru Friday and report any findings to the afternoon CQI meeting. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Facility department heads will complete daily rounds Monday thru Friday and report any findings to the afternoon CQI meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Findings of department head rounds will be reviewed daily Monday thru Friday in the afternoon CQI meeting. Areas of concerns will be addressed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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	was wallpaper scraped off in several places on the north wall. The doors to the outside of the building had door frames appearing to be rust. 12. On 2/24/11 at 7 a.m., the AC hall resident rooms were observed to have entry room doors and door frames scuffed with black marks and paint chipping. In room C 126 outside door frame wood frame was loose from the floor up to 12 inches off floor. A review of the Bed Inventory sheet for this hall indicated there were 14 rooms with 28 residents. 13. The C hall common shower room was observed on 2/24/11 at 7:05 a.m., all walls and floor panels were scuffed up with black marks. There was a soiled shower chair witting outside of the shower with a brown substance on the shower chair cushion. The ceramic tile inside the shower was brown appearing unclean. The clean utility room on the C hall had a cushion and blanket lying on the floor. 14. During an observation of the B hall on 2/24/11 at 7:10 a.m., the following was noted: all resident entry way doors and frames were scuffed up with black marking on all doors. The common activity room outside C			

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	hall one couch, and 2 chairs soiled with dried stains. During a review of the completed facility Bed Inventory sheet, this hall had 8 rooms with 16 residents. 15. On 2/24/11 7:45 a.m. the H hall shower room was observed to have a 4 inch longitudinal chip off the soap dish rack, empty bottle ketaconazole shampoo fell off shower chair. During an interview at that time with CNA #1, she indicated the empty ketaconazole shampoo belonged to one of the resident's on that hall. The shower room on the C hall had a shower chair sitting outside the shower with a dried brown substance on the shower seat. 16. On 2/24/11 at 8 a.m. the following was noted. The common activity room on the Memory Care I unit had wallpaper coming loose in multiple areas and there was a candy wrapper and straw lying on the carpet floor. The Memory Care 1 unit resident rooms were observed to have resident entry doors/frames in disrepair. A review of the completed facility Bed Inventory sheet indicated this unit had 11 rooms with 22 residents. 17. On 2/14/11 at 8:15 a.m., there were 2 of 8 treatment carts in the			

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	facility (one on C hall, the other on the H hall) with soiled dried spills on the top of the carts with a brown colored looked like dried pudding/food. 18. The Maintenance Supervisor was interviewed on 2/25/11 at 9 a.m. to discuss the multiple findings affecting the resident environment. He indicated he and the Administrator were aware of the situation and were working to correct the situation. He indicated he has several painters and other workers currently in the building addressing these multiple environmental findings. 19. The housekeeping supervisor was interviewed on 2/25/11 at 9:30 a.m. to discuss the housekeeping concerns found during this survey. She indicated she was not aware of any shortage of cleaning supplies or any other issues with the sanitary environment.			